Department of Health and Family Services
Division of Health
DOH 0124 (4/98)

State of Wisconsin
ss. 149, Wis. Stats.

Wisconsin Health Insurance Risk Sharing Plan (HIRSP)

Suite 18, 6406 Bridge Road, Madison, Wisconsin 53784-0018
Telephone (608) 221-4551 (local), 1-800-828-4777 (toll free)

CHANGE NOTICE

☐ **PLAN 1, Option A** ($1,000 Deductible)
☐ **PLAN 1, Option B** ($2,500 Deductible)
☐ **PLAN 2 (MEDICARE ONLY)** ($500 Deductible)

1. Last Name	First	Middle	1A. Telephone Number ( )
1B. Residence Address	Number and Street	City / State / ZIP Code	1C. Date of Birth (MM/DD/YYYY)
1D. Social Security Number	1E. Sex ☐ M ☐ F	1F. Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐	

☐ **2. Name Change**

Previous Last Name | First Name | Middle Initial

Reason: ☐ Marriage ☐ Divorce ☐ Other _____ Effective Date ____/____/____

☐ **3. Address Change**

New Address Street | City | State | ZIP Code

Length of residence at current address: From (MM/DD/YYYY) _____ to present date.

☐ **4. Employer Change**

	Your Employer (or parent's employer, if dependent child)	**Spouse's Employer**
Name		
Street Address		
City, State, ZIP		
Telephone		

A. Are you (or your parent, if a dependent child) currently:
☐ **Employed full time** ☐ **Employed part time** ☐ **Self-employed** ☐ **Unemployed** ☐ **Retired**

B. Does your employer, your spouse's employer, or in the case of a dependent child, your parent's employer have a health insurance plan available for employees? ☐ **Yes** ☐ **No**

C. If you answered "YES" to B above, are you eligible for any employer's health insurance? ☐ **Yes** ☐ **No**

D. If you answered "NO" to C above, please give a brief explanation as to why you are not eligible to be insured under your, your spouse's or parent's employer's health insurance plan.

_____

☐ **5. Medicare Eligibility Change**

My Medicare Health Insurance Number is: | | | | | | | | | | | |

Eff. Date ____/____/____
Term. Date ____/____/____

☐ **6. Medicaid Status Change**

Are you currently covered by health insurance benefits under Medicaid (also referred to as Medical Assistance or T-19)? ☐ **Yes** ☐ **No** If "YES," please complete below.

Eligible Effective | | | | | | | | |

Eligibility Terminated | | | | | | | | |

If applicable, complete below.

Medicaid ☐ **Yes** ☐ **No**

If "YES," please provide Medicaid number: | | | | | | | | | | |

Wisconsin Works ☐ **Yes** ☐ **No**

Supplemental Security Income ☐ **Yes** ☐ **No**

☐ **7. Coordination of Benefits Change**

Is anyone named on this notice covered by any other medical plan? ☐ **Yes** ☐ **No**
If "YES," please complete information below.

Name under which policy is listed

Type of Coverage ☐ Health ☐ Dental ☐ Drug ☐ Vision

☐ Single Plan
☐ Family Plan

Name of Other Insurance Company

Effective Date (MM/DD/YYYY) | Policy ID Number | Group Number

Signature Effective Date of Change

_____

Your Signature

X _____

Today's Date | | | | | | | | |

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Signature Effective Date of Change

_____

Your Signature

X _____

Today's Date | | | | | | | | |

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